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A PARTNERSHIP APPROACH TO TACKLING HEALTH INEQUALITIES

PtP CASE STUDY: EASTERN AND COASTAL KENT

MAY 2010

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INTRODUCTION

There is a strong history of partnership working between health and other local partners across Eastern and Coastal Kent. The primary care trust (PCT), NHS Eastern and Coastal Kent, has put a lot of effort, resources and time into partnership working and is now at a stage where it is beginning to reap the benefits.

Working with the local authorities and LSPs across East Kent, the PCT has established a Health and Wellbeing Partnership (HWBP) in each of the six district council areas. These partnerships aim to improve and promote health and well-being at a local level and tackle inequalities. Bringing together the PCT and other key agencies, they work to identify and address the health needs of the local population, including areas of health inequality.

The partnerships receive funding to improve health and wellbeing at a local level and have begun to lay the foundations for localised commissioning of health and care services.

BACKGROUND

1 As a local authority area, Kent County Council covers two PCTs - NHS West Kent and NHS Eastern & Coastal Kent. The wider county area, which includes Medway unitary authority, covers a further PCT, NHS Medway.

2 NHS Eastern & Coastal Kent was formed in 2006. It is the sixth largest PCT in England covering a population of around 730,000 spread over 700 square miles. The PCT covers six district councils: Ashford, Canterbury, Dover, Shepway, Swale and Thanet. However, in 2007 the districts of Canterbury, Dover, Shepway and Thanet merged their Local Strategic Partnerships (LSPs) to create a new East Kent LSP. This means that there are now three LSPs within the area covered by the PCT. It also means that the LSPs are no longer co-terminus with the district councils.

3 An analysis of health and social needs shows some specific challenges for East and Coastal Kent. The population is projected to increase by six percent by 2010 and 16 percent by 2020 and is aging, with a 40 percent rise in the over 65 population predicted by 2020. The geography of the area places limits on the choice and accessibility of local healthcare services. There are larger urban areas along the coastal edges and dispersed rural communities, and transport is a big issue for many people. There are also isolated areas of deprivation, with 17% of the PCT's population living in wards ranked in the top 20% of the most deprived in England and high numbers of people on incapacity benefit.

4 Health status indicators reflect these challenges. Compared with national averages, the population has relatively high morbidity in long-term conditions and mental health and relatively high mortality in cancer and accidental death. There are also some stark health inequalities across East Kent, with significant variations between localities. For example, there is a 57% difference in mortality rates between the 20% most and least deprived wards. There are also a number of groups with additional health needs including prisoners, looked after children, asylum seekers and traveller communities.

EASTERN AND COASTAL KENT PCT MISSION STATEMENT

The PCT's functions are to:

- engage its local population to improve health and wellbeing
- commission a comprehensive and equitable range of high-quality, responsive and efficient services within allocated resources across all service sectors
- directly provide high-quality responsive and efficient services where this gives best value

The PCT also manages the funding to plan and purchase health services for our local community.

PCT vision

To be a national exemplar achieving excellence and best practice.

PCT mission statement

To improve patient experience, wellbeing and health outcomes and to tackle health inequalities for our local population, through intelligent and (where appropriate) integrated commissioning.

Our strategy

The PCT sets out the context in which the PCT is working, clarifying the demographic and health status of the population, as well as highlighting the importance of integrated working and partnerships.

THE CONDITIONS FOR CHANGE

POLICY DRIVERS

5 The Health Act (1999) enabled NHS bodies and local authorities to work together, for example through joint appointments, pooled budgets and joint commissioning. Section 31 of the Act allowed pooling of resources between the Health Service and local authorities in order to achieve more integrated and efficient services.

6 However, the 2006 Local Government White Paper, *Strong and Prosperous Communities* recognised that in many areas collaboration and partnership working were not as strong as it might be. It set out ambitions for more 'systematic partnership working between NHS bodies, local authorities and other partners', building on the 2006 Health White Paper, *Our Health, Our Care, Our Say.*

7 One of the proposals in the White Paper was to legislate for health and well-being partnerships under the LSP to become statutory partnerships. Alongside this, the White Paper proposed introducing a duty for upper-tier authorities to prepare the Local Area Agreement (LAA) in consultation with partners, including PCTs, NHS Health Trusts and NHS Foundation Trusts, and a duty for named partners to co-operate with each other in agreeing LAA targets.

8 At the time of the 2006 White Paper there were still six LSPs in East Kent; of these, only two (Canterbury and Swale) had a health and well-being sub-group in place.

9 At the same time, locally the PCT recognised that partnership working is crucial to tackling health issues and delivering the PCT's vision. Other policy drivers, including the LAA and, more recently, the Comprehensive Area Assessment (CAA), have placed a further focus on partnership working.

A STRONG HISTORY OF COLLABORATIVE WORKING

10 There is a strong history of partnership working across Kent and the PCT has good working relationships with its partners.

11 The Director of Public Health is a joint appointment between the PCT and Kent County Council (reporting directly to the Chief Executive of Kent County Council). Use is made of Section 31 agreements and there are integrated planning and joint commissioning arrangements in place with local authorities, social services and voluntary and community services - especially around integrated care services, the urgent care programme and drug and alcohol care. There are plans to have joint commissioning arrangements in place for all integrated care by 2011.

12 The Kent Children's Trust was established in 2006 and in September 2008 23 Local Children's Services Partnerships (LCSPs) went live across Kent. These work under the Children's Trust and bring together representatives from Kent County Council, schools, social care, district councils, health and the police, as well as other voluntary services and agencies who work with children.

13 NHS Eastern & Coastal Kent is a member of all three LSPs within its area. It is reviewing its governance arrangements for partnership working to ensure it provides effective support and value for money.

EASTERN AND COASTAL KENT PCT MISSION STATEMENT

The PCT has three main priority strands for partnership working:

- **Commissioning** – particularly through the private, public and community sector
- **Policy influence** – influencing partners to change their policies, rather than just commissioning them to do things differently
- **Corporate and social responsibility** – meeting the PCT's statutory responsibilities and its social responsibilities around sustaining its third sector. This is especially important in the current economic climate when many third sector organisations are in vulnerable financial situations. The PCT recognises that if the third sector is supported to respond more to the PCT's needs, then the PCT can commission more with them. For example, the PCT offers 3 year rolling contracts with voluntary and community sector providers and has introduced full cost recovery. Voluntary sector Compacts are also in place for the County and each District Council.

It also has a specific post that is focused on partnership working. Caroline Davis is Assistant Director of Strategic Partnerships in the Public Health Directorate. Her role involves working with local authorities and other public bodies to promote and support collaborative working.

THE LOCAL AREA AGREEMENT

14 The Kent Agreement was signed in 2005. It combined Kent's first Local Area Agreement (LAA) and its second generation Local Public Service Agreement (LPSA2). The Kent Agreement included four outcomes within its Healthier Communities and Older People block:

- To increase independence through reducing worklessness among those who are able to work
- To improve the health of Kent's residents, and reduce health inequalities by addressing variations in health across the county
- To ensure that Kent residents have access to homes of excellent quality, in the right place, at the right time and at the right cost
- To promote independent living for all - focusing on vulnerable people.

15 The LAA provided a focus for partnership working across health and other sectors. The inclusion of housing and employment outcomes highlighted the commitment to working across traditional agency or sector boundaries to deliver integrated approaches to improving the health of Kent's communities.

16 The PCT knew that it had to deliver against the LAA health-related indicators in order to deliver against its own priorities regardless of what other partners did. But it recognised that working collaboratively with other partners would make it much easier to deliver these priorities.

17 The second LAA (KA2) is now in place. It includes three key health-related national indicators:

NI 39 – alcohol related admissions to hospital
NI 55 – Childhood obesity in reception year
NI 120 – All age all cause mortality

18 In addition, over half of the LAA impacts on health inequalities in a positive way, including health-related indicators around reducing smoking, obesity, substance misuse and teenage conceptions and improving sexual and mental health.

ESTABLISHING HEALTH AND WELL-BEING PARTNERSHIPS – THE PROCESS

19 In 2006, NHS Eastern & Coastal Kent began work to establish a health and wellbeing partnership (HWBP) in each of the six district council areas, building on the two health and wellbeing LSP sub-groups already in place in Canterbury and Swale.

20 Six HWBPs are now in place across Eastern and Coastal Kent, most of which have been up and running for around 2 ½ years. They aim to focus on the delivery of health and wellbeing outcomes relevant to the local population and partners.

21 The key stages in the development of these partnerships are listed below:

STEP 1: PROVIDING ADMINISTRATIVE SUPPORT TO GET THE PARTNERSHIPS OFF THE GROUND

22 The PCT, through the Public Health Directorate, has provided the necessary administrative support to get the HWBPs off the ground and to manage and run each partnership.

STEP 2: GETTING THE MEMBERSHIP AND GOVERNANCE ARRANGEMENTS RIGHT

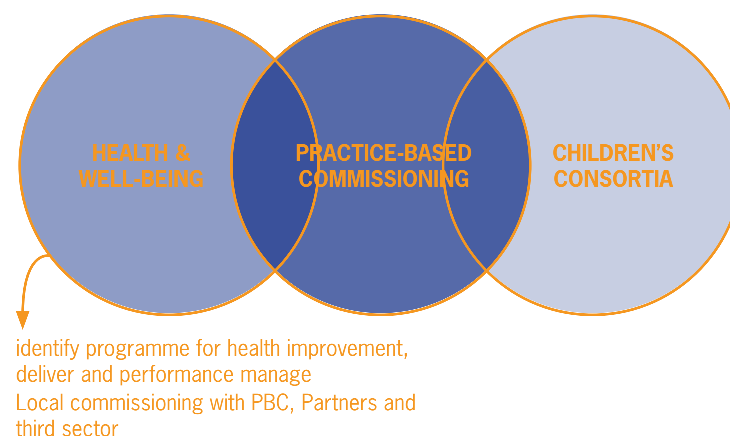
23 The HWBPs have a broad membership drawn from a range of local partner organisations, typically including the PCT, local authorities (district and county), the community and voluntary sector, the private sector, Practice Based Commissioning manager, Jobcentre Plus, and Patient & Public Engagement. Each partnership is chaired by a PCT Director, who is aligned to the relevant district.

24 Although the partnerships follow district council boundaries, they each report to the relevant LSP, effectively forming a sub-group of the LSP. Following an internal PCT review of the Health and Social Wellbeing Partnership Boards, they will now also report into practice based commissioning clusters, and through these, report into the PCT.

25 Each partnership is based on a standard model with a core memorandum of understanding and terms of reference etc., but they also have some flexibility to reflect a local flavour.

26 They link closely with other local partnerships e.g. Community Safety Partnerships, Children's Trusts and Economic Partnerships. They also link into the county-level health and wellbeing thematic partnership – Kent Public Health Board - through the PCT members. The Kent Public Health Board is one of five thematic working partnerships that sit below the Kent Partnership (the countywide LSP). It is chaired by the Director of Public Health and comprises senior representatives from key partner agencies. Kent Public Health Board is directly responsible for the health-related performance indicators in KA2 and drives performance management of these indicators vertically through the Board. A performance framework has been developed, with performance plans.

27 The HWBPs also act as a conduit between local partners and the 8 Practice Based Commissioning (PBC) groups across Eastern and Coastal Kent, which in turn have links with the Children's Consortia (statutory partnerships supporting children and young people). As well as delivering and funding projects, the HWBPs contribute to some extent to local commissioning by the PBC groups and other partners.



STEP 3: AGREEING PRIORITIES

28 The overarching aim of the HWBPs is to enable people to live healthier, longer lives and reduce health inequalities in the locality.

29 The outcomes agreed in Kent's second LAA (KA2) provide a focus for their work, by forming the basis of the priorities for each partnership.

30 Kent Public Health Observatory produced baselines and trajectories for all the KA2 health indicators by county level, local district level, PCT level (for both NHS Eastern & Coastal Kent and NHS West Kent), and East Kent LSP level. Caroline Davis at the PCT used this data to produce a data pack for each partnership, which included performance against all key KA2 health targets. The partnerships used these data packs to help agree their own key local health priorities to sit alongside PCT-identified priorities.

STEP 4: FUNDING DELIVERY OF LOCAL PROJECTS

31 In 2007 NHS Eastern & Coastal Coast established the Health and Wellbeing Fund to provide each HWBP with £100,000 per year for three years. The initial three year funding period ends in March 2010. The total fund available over the three years is £1.8 million.

32 The Fund is administered within the PCT by Public Health, but the HWBPs have delegated powers to make decisions on where the Fund is spent. In this way, the PCT is the only organisation on the LSP to put actual funding directly into the LSP 'pot'.

33 Each HWBP uses the Fund to "commission" local providers to deliver small-scale projects. Any organisation on the LSP or one of its sub groups can apply for the funding (including voluntary and community organisations and groups), except for individuals, private businesses or organisations which are in a poor financial position or whose financial management systems are not in good order.

34 The HWBPs invite proposals for projects against a standard set of criteria, published by the PCT, which includes guidance on eligible organisations, what types of things can be funded and timelines. The criteria are tailored to each partnership to reflect the local priorities against which funding applications are scored. For example, in 2009/10, Ashford HWBP has decided to focus funding solely on healthy weight in young people.

35 All HWBPs issue a standard application form for proposals. There is also a standard set of guidance for assessing funding bids. Local panels decide where the Fund will be spent and each bid is given a score out of 10 against a set of criteria, including:

- extent to which it supports the key priorities of the individual HWBP (specific to Ashford)
- evidence of need

WHAT HAS BEEN ACHIEVED?

- engagement of other partners
- likely health benefit (perceived and actual)
- ability to deliver
- extent to which it responds to the Growth Agenda
- patient, public and community involvement
- exit strategy
- measurable outcomes/outputs
- matched funding/leverage
- value for money

36 Applications are considered for projects that run for either one or two years.

37 Applicants are given an eight week window (Jan-Feb) to apply for funding and decisions are made by 31st March in order to release funding right at the beginning of the financial year in April. Successful applicants sign a Service Level Agreement (SLA) with the PCT detailing the outputs and outcomes of the project in order to release funding and begin service delivery. The SLA is managed by a member of the PCT contract team who monitors the project on a quarterly basis. Unsuccessful applicants are given both written and verbal feedback on their bids.

38 For the 2008-09 Fund the number of bids received per partnership ranged from 19 (Shepway) to 42 (Thanet). The amounts of funding granted tend to be small, for example the value of approved bids in 08-09 ranged from £800-£40,000. Projects are mainly one-off activities, such as bike sheds to enable Ashford school children to cycle to school and funding for play equipment. Some however are ongoing activities, for example regular singing and music making sessions for older people in Shepway and Ashford, and support for day-to-day management costs for The Scrine Foundation's Resettlement and Tenancy Sustainment Team, working from the Thanet Open Centre with vulnerable and marginalised people who find themselves homeless or vulnerably housed in the Thanet District.

39 In practice, this system is more like grant aid than a localised commissioning process. But, as Carolyn Davis notes, "It has enabled local partners – including from the voluntary and community sector – to get involved in identifying local health needs and commissioning services to address these. It also provides an opportunity to pilot some more innovative and experimental projects".

40 The PCT has recently reviewed the first two years of the Health & Wellbeing Fund (2007-2009). The findings of the review (Spring 2009) show that, while the HWBPs are continuously evolving and developing, a number of benefits are evident. These include:

- **A positive relationship with the local voluntary and community sector (VCS) –** The HWBPs have helped the PCT to build a good relationship with VCS organisations and have helped to build capacity in the sector. The sector brings a lot to the table, for example it plays a particularly strong role in supporting and delivering 'softer' health and well-being outcomes and in supporting the preventative agenda.
- **Strengthened links between local partners –** The partnerships have also facilitated positive relationships across different local partners and partnerships (e.g. Local Children's Services Partnership and Practice Based Commissioning Groups), helping to align their strategies and practice. They have also contributed to the local area's Sustainable Community Strategy (SCS).
- **A local focus on services –** The HWBPs provide a focus for targeted working within a particular area, helping to draw together the work of a range of partners around some key priorities.
- **User-led service innovation –** The HWBP Fund has enabled small providers to get involved in delivering health services, further developing local competition for service delivery and helping to deliver new and innovative ways of working at a very local level. Small local providers often have closer links to the communities they serve. For example, local VCS groups have done some innovative work around Public and Patient Engagement (PPE), which has flagged up areas of work that the PCT might not have thought of doing. Small providers can also respond more quickly and deliver services that reflect local needs and are more flexible than some of the PCT's larger contractors, offering good value for money.
- **Positive public relations –** The HWBPs and their associated funding pots have helped give the PCT some positive PR and improved relationships between the PCT and local communities. The partnerships have also helped to raise the profile of the PCT with partners. Nationally, the HWBPs have been identified as best practice (in a 2008 IDeA report on health inequalities) and research shows that NHS Eastern & Coastal Kent is one of the only PCTs in the country to put real money into LSPs / their sub-groups.
- **Shared intelligence about local health needs –** The HWBPs have led to some good work around sharing data across themes, with strong support from the Kent Public Health Observatory.
- **Additional funding –** In addition to the Health and Wellbeing Fund some partnerships have managed to draw in match funding for activities.

KEY LESSONS

41 Following a review by the Audit Commission and an internal review by the PCT a number of key lessons have been identified:

42 **Ensure clarity of purpose**. Review Terms of Reference so that each HWBP can discuss and 'own' the role of the partnership. Ensure members that attend can fulfil their role on the group. Consistent and appropriate membership of the HWBP ensures that the HWBP is an active partnership and is able to make decisions and hold partners to account.

43 **Develop action plans to address key health inequalities to which the HWBP can add value.** By mapping the activity by partners to address health inequalities and identifying what part if any the HWBP plays in this, the HWBP can add value to the total work in this area. It will also deliver against a key criterion of the Audit Commission Review, which is the development of action plans.

44 **Reinforce the role of the HWBP as part of the LSP.** Ensure reports go to the LSP and issues discussed if needed.

45 **That a report covering all 6 HWBPs be submitted to the Commissioning Strategy Committee on a regular basis, detailing activity by the partnership.** This will provide evidence of how the HWBPs are delivering against PCT Objectives, including World Class Commissioning (WCC) compliance, and identify opportunities and links across other areas of the PCT.

46 **Representatives from PBC and Children's Trust to attend the HWBPs.** Improving links between PBC and the HWBPs will lead to development of other service models, including PBC commissioning preventative services (or accessing those already in place) from partners.

47 **Ensure that links to the public and the seldom heard are developed, via the Local Improvement Network (LINk) and other networks.** Demonstrate that the decisions made by the HWBP reflect the needs of the community and provide additional WCC evidence

48 **Evaluate projects previously funded by the HWPB; produce report for SCS to discuss.** Based on this develop a rationale for continuation of the fund. The HWBP fund has been well received by partners; it has delivered some tangible benefits, but these need to be properly evaluated. The provision of seed corn funding to develop new service models sends a positive signal to partners. However, the link to sustained commissioning arrangements needs to be put in place.

49 **Formalise the use of Community Development Workers to take the Action Plans forward.** This will ensure that activity takes place, and that it delivers against PCT and partners objectives.

SUCCESS FACTORS

- **A dedicated partnership coordinator** – Having a dedicated Assistant Director of Strategic Partnerships provides a focus for the HWBPs and helps to maintain commitment and momentum. Caroline Davis provides the strategic framework, makes links to other partnerships, ensures that the HWBPs do not exist in a void and helps to share learning.
- **Strong personalities** – Like any partnership, personalities are key to securing buy-in and sustaining commitment. Caroline plays an important role in building and brokering relationships with partners, and tries to bring some energy to the partnership agenda. Caroline believes in the 'softer', inter-personal element of partnership working, as well governance and performance: 'I'm a believer in value of the 'tea and a chat' side of partnerships; it helps build relationships and trust between partners, which is often half the challenge'.
- **Managing expectations** - The HWBPs try to manage expectations around funding by publicising the Health and Wellbeing Fund through established networks, rather than sending details out to all local groups.
- **Senior buy-in** – Support and engagement from the PCT Chief Executive and Chairman has really helped to raise the profile of the HWBPs and get buy-in from other partners.
- **Resources** – The success of the HWBPs is largely down to the fact that the PCT put real money into them, as well as staff time and resources.
- **Recognising all partners' priorities** – The HWBPs are not just focused on the PCT's commissioning cycle; they also aim to help deliver against Kent County Council's, the district councils' and partners' priorities.

WHAT NEXT?

50 The Review of Health and Well-Being Partnership Fund (2007–2009) has identified a number of future developments. These include:

STRENGTHENING COMMISSIONING ARRANGEMENTS

51 Intelligent commissioning is central to achieving the PCT's vision. NHS Eastern & Coastal Kent sees the Department of Health's World Class Commissioning agenda as an opportunity to transform the way health and care services are commissioned to deliver better health and well-being for all.

52 The PCT is mindful that whilst it aims to deliver improved health and well-being outcomes, it also needs to deliver the PCT's 5 key commissioning priorities. These are identified in the PCT's recent Strategic Commissioning Plan (2008-2013):

- Breaking the cycle of inequalities
- Revolutionising services for older people
- Tackling the killers of vascular disease, cancer and respiratory disease
- Promoting well being and good mental health
- Transforming the life chances of disadvantaged children.

53 If the PCT continues to fund local providers to deliver on the Health and Wellbeing agenda, a clear process outlining how this links to the wider commissioning intentions of the PCT (e.g. through HWBP action plans, PBC or Local Children's Services Partnerships' (LCSP's) plans) will need to be developed.

STRONGER LINKS WITH PRACTICE BASED COMMISSIONING

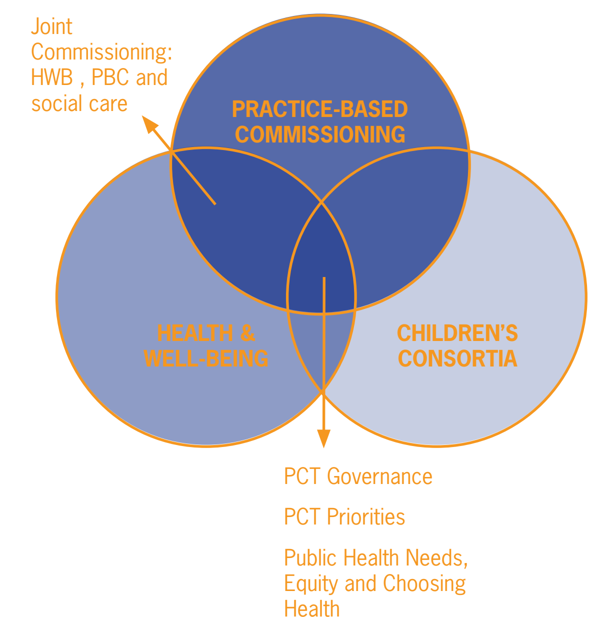
54 Linked to the above, the aim is for the HWBPs to link much more closely with Practice Based Commissioning (PBC) so that they can help deliver PBC plans, and vice versa.

55 Currently the services that have been developed by the HWBPs are responsive to local needs but are driven by providers. As Caroline Davis notes:

'Looking ahead, the idea is that by strengthening the link to PBC, future service developments can be driven in part by PBC commissioning intentions. In addition the HWBP will be able to influence the commissioning intentions of the PBC clusters and be part of the development process for these plans.'

56 To enable this, the HWBPs will need to be formerly identified as part of the PBC commissioning intentions process, and in turn the PBC commissioning intentions will feed into the HWBP priorities and locality plans.

57 The longer-term aim is that the HWBPs, PBC and Children's Consortia will all be linked much more closely to strengthen the commissioning process. This is shown in the diagram below. Already, initiatives to strengthen links between HWBP and practice based commissioning are being piloted in Thanet.



DEVELOPMENT OF HEALTH INEQUALITIES STRATEGIES

58 Each HWBP will develop a short Health Inequalities Strategy. These will be driven by an analysis of locality-level Public Health data. They will also support the Sustainable Community Strategy, KA2 Local Area Action Plans, Joint Strategic Needs Assessments (JSNA), Commissioning Intentions and PBC Locality plans. These will then identify what the key priorities are for the particular HWBP and how they will be supported and delivered. For example: whether a particular priority is already identified for delivery in other delivery plans; how services will be funded; and where new services will need to be commissioned, and by whom.

CLOSER SCRUTINY OF HEALTH AND WELLBEING PARTNERSHIPS

59 The PCT also has ambitions to develop scrutiny arrangements around health and wellbeing. This will help to raise the profile of the HWBPs with elected members and will help the partnerships to tighten their focus and demonstrate their added value. Caroline is keen that this follows a select committee approach based around fact finding, rather than traditional 'finger wagging'.

PHOTO CREDITS

credit Karen Withak p2, John Linwood p9, Caroline Davis p4, 7, 8 & 10, kenneth John Brown p11, Yersina p14, Dan Davidson p15.

MORE INFORMATION

More information on the Health and Wellbeing Partnership Groups can be found on the NHS Eastern & Coastal Kent website at:
www.eastkentcoastalpct.nhs.uk/home/about-us/investment-into-action/health-and-wellbeing-partnership-groups

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